Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA MEDICAL CENTER
P O BOX 849770
DALLAS TX 75284

Carrier's Austin Representative Box
Box Number 01

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE CO

MFDR Date Received
APRIL 29, 2007

MFDR Tracking Number
M4-08-2296-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the Letter of Reconsideration Dated April 17, 2007:
"Medically necessary services were rendered to your member as ordered by a credentialed physician; yet reimbursement was denied due to lack of authorization for continued confinement…The patient registered at our facility and provided Medicare Insurance information. When claim was sent to Medicare it rejected stating patient was covered by other insurance. The patient was then contacted at home and at this time he advised us that this particular condition was work related and provided us with the correct insurance information. A claim was subsequently mailed to Liberty Mutual."

Amount in Dispute: $27,285.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee guidelines and the Texas Department of Insurance, Division of Workers' Compensation Acts and Rules. The charges for this inpatient stay were not preauthorized as required by TDI rules."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30503

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2006 Through June 23, 2006	Inpatient Hospital Services	$27,285.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 23, 2007
   - 62 – X170 – PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER TWCC RULE 134.600. (X170)
   - W1 – Z695 – THE CHARGES FOR THIS HOSPITALIZATION HAVE BEEN REDUCED BASED ON THE FEE SCHEDULE ALLOWANCE. (Z695)

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   (A) An emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) Preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(1) requires preauthorization of "Inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   Review of the submitted documentation finds that the requestor did not submit documentation to support preauthorization was obtained for the inpatient hospital services performed from June 21, 2006 through June 23, 2006.

2. The division concludes that the disputed services required preauthorization per 28 Texas Administrative Code §134.600(p)(1). The requestor did not submit documentation to support preauthorization was obtained. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 29, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	November 29, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.